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An Independent Review Organization

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DATE NOTICE SENT TO ALL PARTIES: May/20/2015

IRO CASE #:

DESCRIPTION OF THE SERVICE OR SERVICES IN DISPUTE: occupational therapy 12 sessions left hand

A DESCRIPTION OF THE QUALIFICATIONS FOR EACH PHYSICIAN OR OTHER HEALTH CARE PROVIDER WHO REVIEWED THE DECISION: D.O., Board Certified General Surgery

REVIEW OUTCOME: Upon independent review, the reviewer finds that the previous adverse determination/adverse determinations should be:

☒ Upheld (Agree)

☐ Overturned (Disagree)

☐ Partially Overturned (Agree in part/Disagree in part)

Provide a description of the review outcome that clearly states whether medical necessity exists for each health care service in dispute. It is the opinion of this reviewer that the request for occupational therapy 12 sessions left hand is not recommended as medically necessary

PATIENT CLINICAL HISTORY [SUMMARY]: The patient is a male who reported an injury to his left hand. The clinical note dated 01/02/15 indicates the patient complaining of ongoing left hand pain. The note indicates the patient utilizing a splint. There is indication the patient is continuing with edema. The patient had been recommended to initiate physical therapy at that time. The therapy note dated 01/22/15 indicates the patient continuing with left hand pain with associated stiffness and swelling. The note indicates the initial injury occurred when he poked his hand into a knife and subsequently underwent treatment in the emergency room where he was provided with closure including stitches. The patient reported 4 days after the incident, he was unable to move his fingers. The patient subsequently underwent an evaluation where a disruption to the FDS was identified. A surgical repair was completed on 02/12/14, with a subsequent initiation of occupational therapy the following month. A scar tissue adhesion was identified which required a tenolysis which was completed on 12/12/14. The patient rated the ongoing pain as 3-8/10. The patient did describe difficulties with his ADL's to include self-care, dressing, grooming, and household chores. The patient also reported greater difficulty at the end of each day. Upon exam, the patient was able to demonstrate 60 degrees of left wrist flexion, 60 degrees of extension, and 23 degrees of ulnar deviation along with 25 degrees of radial deviation. The therapy note dated 02/27/15 indicates the patient continuing with therapy. The patient rated his ongoing pain as 4-5/10. There is an indication the patient had demonstrated 65 degrees of left wrist extension. However, the patient was identified as having a regression with his range of motion to include 55 degrees of left wrist flexion with 20 degrees of ulnar deviation at 10 degrees of radial deviation. The clinical note dated 03/24/15 indicates the patient utilizing a dynamic splint while at work. No contractions were identified at the patient's affected fingers. However, the patient did report a catching sensation at the radial side of the wrist when abducting the thumb, as well as supination of the wrists. The patient was unable to fully make a fist.

The MRI of the left wrist dated 04/11/15 revealed tenosynovitis at the flexor digitorum of the

index finger. A prominent hypointense signal was also identified at the flexor pollicis longus tendon. The clinical note dated 03/24/15 indicates the patient reporting ongoing left wrist pain. The patient continued to report a catching sensation at the radial region of the wrist. The therapy note dated 04/13/15 indicates the patient continuing with left wrist pain. Strength deficits were identified at the abductor pollicis longus, the extensor pollicis longus, and the flexor pollicis longus. The patient was being recommended for additional occupational therapy at the left wrist at that time. The utilization reviews dated 04/17/15 and 04/28/15 resulted in denials as insufficient information had been submitted regarding the patient's clinical findings confirming the likely benefit of additional therapy.

ANALYSIS AND EXPLANATION OF THE DECISION INCLUDE CLINICAL BASIS, FINDINGS AND CONCLUSIONS USED TO SUPPORT THE DECISION: The documentation indicates the patient continuing with complaints of left wrist pain, with associated range of motion deficits. There is an indication the patient had completed 21 occupational therapy sessions to date, following the left wrist tenolysis. Additional therapy would be indicated provided the patient meets specific criteria to include significant functional deficits continuing at the affected area, along with functional improvement through the initial course of treatment. There is an indication the patient is continuing with minimal range of motion deficits along with minimal strength deficits identified at the left wrist. Given the minimal strength and range of motion deficits at the left wrist, it does not appear the patient would not require additional therapy within the formal setting. Given the completion of a full course of treatment following the tenolysis, it would be reasonable for the patient to progress to a home exercise program at this time. Additionally, it should be pointed out that the request involved a total of 7 modalities as well as a re-evaluation for the patient. Therefore, the requested number of modalities is in excess of the recommended number of modalities, to be no more than 4 within any one therapy session. Given these factors, the request is not indicated as medically necessary. As such, it is the opinion of this reviewer that the request for occupational therapy 12 sessions left hand is not recommended as medically necessary and the prior denials are upheld.

A DESCRIPTION AND THE SOURCE OF THE SCREENING CRITERIA OR OTHER CLINICAL BASIS USED TO MAKE THE DECISION:

☐ ACOEM-AMERICA COLLEGE OF OCCUPATIONAL & ENVIRONMENTAL MEDICINE UM KNOWLEDGEBASE

☐ AHCPR-AGENCY FOR HEALTHCARE RESEARCH & QUALITY GUIDELINES

☐ DWC-DIVISION OF WORKERS COMPENSATION POLICIES OR GUIDELINES

☐ EUROPEAN GUIDELINES FOR MANAGEMENT OF CHRONIC LOW BACK PAIN

☐ INTERQUAL CRITERIA

☒ MEDICAL JUDGEMENT, CLINICAL EXPERIENCE, AND EXPERTISE IN ACCORDANCE WITH ACCEPTED MEDICAL STANDARDS

☐ MERCY CENTER CONSENSUS CONFERENCE GUIDELINES

☐ MILLIMAN CARE GUIDELINES

☒ ODG-OFFICIAL DISABILITY GUIDELINES & TREATMENT GUIDELINES

☐ PRESSLEY REED, THE MEDICAL DISABILITY ADVISOR

☐ TEXAS GUIDELINES FOR CHIROPRACTIC QUALITY ASSURANCE & PRACTICE PARAMETERS

☐ TEXAS TACADA GUIDELINES

☐ TMF SCREENING CRITERIA MANUAL

☐ PEER REVIEWED NATIONALLY ACCEPTED MEDICAL LITERATURE (PROVIDE A DESCRIPTION)

☐ OTHER EVIDENCE BASED, SCIENTIFICALLY VALID, OUTCOME FOCUSED GUIDELINES (PROVIDE A DESCRIPTION)